

Verification of Informed Consent

for Antipsychotic Medication in Skilled Nursing Facilities

Antipsychotics and Dementia

Antipsychotic medications are sometimes prescribed for dementing illnesses with associated behavioral and psychological symptoms. Except in emergency situations (where the health and safety of the resident or others is threatened), antipsychotics should only be considered after environmental, medical, psychological, and comfort assessments have failed to identify the cause of the resident's behavioral and psychological symptoms and other options have proven insufficient to relieve the resident's distress. Increasingly, antipsychotics are viewed as a dangerous and ineffective method for addressing behavioral symptoms of dementia, but in some cases, may be a necessary and effective treatment for the medical/psychiatric conditions listed below.

The Food and Drug Administration (FDA) has issued a Public Health Advisory for antipsychotic medications. The FDA determined that the death rates are higher for elderly people with dementia when taking this type of medication. Antipsychotic medications are not FDA approved for the treatment of behavioral disorders in patients with dementia. Source: National Institute of Mental Health U.S. Department of Health and Human Services, www.nih.gov

If an antipsychotic is being prescribed for behavioral and psychological symptoms of dementia (BPSD), the box for non-FDA-approved use should be checked below.

NOTE: Consent may be withdrawn by the resident or their representative at any time.

Resident: _____

Medication: _____

Typical Dosage Range: _____

Resident's Prescribed Dosage: _____

This antipsychotic medication is prescribed for (medical condition/psychiatric diagnosis)

- | | |
|---|--|
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Schizophreniform disorder |
| <input type="checkbox"/> Schizoaffective disorder | <input type="checkbox"/> Psychosis NOS |
| <input type="checkbox"/> Delusional disorder | <input type="checkbox"/> Atypical psychosis |
| <input type="checkbox"/> Brief psychotic disorder | |
| <input type="checkbox"/> Mood disorders (e.g. mania, bipolar disorder, depression with psychotic features, and treatment-refractory major depression) | |
| <input type="checkbox"/> Medical illness or delirium with manic or psychotic symptoms and/or treatment-related psychosis or mania (e.g., thyrotoxicosis, neoplasms, high-dose steroids) | |
| <input type="checkbox"/> The following Non-FDA-approved use : | |

Potential / Expected Benefits:

Side Effects / Severity of Risks:

Possible Alternatives, Including Non-drug Options:

Informed Consent Verification

I have discussed with _____,

(Check one box or both: resident resident's representative) **the following:**

- The reason for the treatment and the nature and seriousness of the resident's illness;
 - The nature of the proposed treatment including frequency and duration;
 - The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment;
 - The nature, degree, duration and probability of the side effects and significant risks (e.g., FDA boxed warning), commonly known by the health professions;
 - The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment;
 - That the resident has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.
- The above-named resident and/or the resident's representative has given permission for use of the medication.
- The above-named resident has given permission to contact a designated family member regarding the use of antipsychotic medication.
- The above-named resident has **not given permission** to contact a designated family member regarding the use of antipsychotic medication.

Ordering Prescriber's Signature

Date

Resident's / Resident's Representative's Signature

Date

**DO NOT SIGN if you have not received information from the
prescribing health care provider about the use of this medication.**

The signature of the resident or resident's representative could not be obtained despite diligent effort.
Confirmation of consent was obtained from

_____ on (Date) _____

Licensed Nurse Signature Verifying Informed Consent

Date

- Attached information about the medication and a copy of this form has been provided to the resident and/or resident's representative.

For more information about this antipsychotic medication, please contact your practitioner or go to
<http://www.nlm.nih.gov/medlineplus/druginformation.html> or
<http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm>